EXHIBIT H

Tennessee Urology Associates
7557 Dannaher Drive, Suite 23
Powell, TN 37849

LEE CONGLETON, III, M.D.

Patient Name: Forester, Karen
Shared ID: 78041284
DOB: [redacted]
Date: 2-25-2016

Ms. Forester is a 51-year-old white female evaluated today for a history of several urologic problems that began in approximately 2005 when she began having worsening stress incontinence. She was followed by Dr. Rauls, a gynecologist in Arkansas, who felt that she had stress incontinence and he encouraged her to perform Kegel exercises for several years with no long term improvement noted by the patient. Ms. Forester in 2008 underwent a TVTO sling by Dr. Rauls and did very well postoperatively. She resolved her stress incontinence and had no other problems until 2011. The patient at that time began having severe intermittent vaginal pain and also dyspareunia. This pain occurred suddenly and was not associated to any other activity. She did have pain with intercourse also and this pain and intermittent dyspareunia were bothersome intermittently for several years after 2011. Changing position with intercourse sometimes helped the dyspareunia. Interestingly, both the dyspareunia and pelvic pain had resolved for the most part over the last several months.

The patient also has a history of urge incontinence and some stress incontinence which began to occur around the same time. She now has worsening nocturia, up to two to four times a night. She wears a pad now continuously. She was tried apparently on Vesicare for a short period which she states did not seem to help her symptomatically in 2012 when she was evaluated by another physician, Dr. Emerson. The patient reports that the leakage with coughing, sneezing, and laughing is present but seems to be less of a problem than the urge incontinence upon my discussion with her. She has occasional enuresis but this is only a small amount. She denies any history of UTIs or hematuria or stones. Patient denies incomplete bladder emptying but her bladder scan today did show a residual of 246 cc.

PAST MEDICAL HISTORY: Significant for a series of urethral dilations as a young child because of her history of bedwetting and incomplete bladder emptying. Patient was also given a pill at night to take to keep from bedwetting which helped at the time. She had no history of UTIs that she reported. Patient denies any history of hypertension, heart disease, lung disease, diabetes, or cancer.

SURGICAL HISTORY: She did have an appendectomy in 1996.

CURRENT MEDICATIONS: None.

ALLERGIES: PENICILLIN, SULFA.

SOCIAL HISTORY: She is a non-smoker. She is married. She works for Jonesborough Public Schools.

FAMILY HISTORY: Unremarkable for urologic disease.

REVIEW OF SYSTEMS: As per the medical history sheet and reviewed by me.

PHYSICAL EXAMINATION: Well developed, well-nourished female in no acute distress. Alert and oriented x 3. Neck without masses. Respirations are non-labored. Cardiovascular exam: Reveals a regular rate and rhythm. There is no peripheral edema. GI: Abdomen is soft and non-tender without masses. No hepatosplenomegaly or hernia. There is no CVA tenderness. Skin is without obvious rashes or lesions. Neurologically, the patient is grossly intact. There is no lymphadenopathy. GU exam: Labia and vaginal vault with normal appearance. Urethra normal, meatus normal, bladder neck well supported. The sling is palpable and seems to be in good position in the mid-urethral area. There is no tenderness over the sling. She does have some mild vaginal tenderness well proximal to the sling anteriorly with a second degree cystocele present. She has mild uterine prolapse as well.

URINALYSIS: Showed 1+ RBCs but she is menstruating and she refused a catheterized specimen.

BLADDER SCAN: Post void residual was 246 cc.

ASSESSMENT:

1. Overactive bladder.
2. Urge incontinence secondary to #1.

3. Nocturia.
4. Stress incontinence mild
5. Incomplete bladder emptying.
6. Status post TVT-O sling in 2011.
7. Cystocele.
8. Pelvic pain, possibly related to cystocele.
9. Dyspareunia, possibly related to cystocele and incomplete bladder emptying.

PLAN:

1. I discussed findings with patient. It seemed on my exam, and she agreed, that upon palpating the sling it seemed to be non-tender. It was in the appropriate mid urethral position without any evidence of erosion or inflammation. The sling in my opinion is still probably improving her continence and I would definitely not recommend removing.
2. We discussed the mild tenderness which was found in the mid-anterior vaginal vault proximal to the sling.
3. We discussed the possibility of a cystocele repair which may be helpful in the future.
4. We discussed her incomplete bladder emptying. If this post void residual is consistent, it could greatly worsen her overactive bladder symptoms. I encouraged her to be evaluated by a urologist locally in Jonesborough who could help her with her bladder emptying and possibly do urodynamic studies to further assess her bladder function.
5. We discussed the possibility that overactive bladder medications could be very effective helping her urge incontinence and overactive bladder symptoms.
6. Patient seemed agreeable with this plan to be further evaluated and also with my recommendation not to attempt to have the sling removed. I do not feel the sling is contributing to her discomfort which she admits is greatly improved at this time.

Lee Congleton, III, M.D./ kp

Electronically signed by Lee Congleton, III, M.D.